Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING
October 5, 2006
Elihu M. Harris State Building
Oakland, California

In Attendance

Chair Angie Wei
Commissioners Allen Davenport, Alfonso Salazar, Kristen Schwenkmeyer, Robert B. Steinberg, Darrel "Shorty" Thacker and John Wilson
Executive Officer Christine Baker

Not in Attendance

Commissioner Leonard C. McLeod

Call to Order

Chair Angie Wei, 2006 Chair of the Commission, called the meeting to order at 10 a.m.

Minutes from the April 6, 2006 Meeting

CHSWC Vote
Commissioner Thacker moved to approve the Minutes of the July 6, 2006 meeting, and Commissioner Wilson seconded. The motion passed unanimously.

Spinal Surgery Second-Opinion Presentation and Final Report
Christine Baker, CHSWC Executive Officer
Lachlan Taylor, Workers' Compensation Judge
Frank Neuhauser, UC Berkeley Survey Research Center
Irina Nemirovsky, CHSWC

Mr. Neuhauser stated that this would be the final report to the Commission on the spinal surgery second-opinion process (SSSOP). He stated that work began on the SSSOP after it was introduced a couple of years ago. Since then, Doug Strand, Ph.D., UC Berkeley, helped with survey analysis, and Commission staff Irina Nemirovsky and Chris Bailey and Nurgul Toktogonova were instrumental in gathering data from the Division of Workers' Compensation (DWC) files.

Mr. Neuhauser stated that he would review some of the data reviewed last year before the survey was done. He stated that when this process was adopted, the first concern was that hospital costs were rising rapidly in the workers' compensation system. Through 2003, paid hospital costs, as reported by the Workers' Compensation Insurance Rating Bureau (WCIRB), have been second only to pharmaceutical costs as the fastest growing area of workers' compensation cost growth, increasing by 16 percent in just six years. There was concern that

this was driven by back surgeries which are among the most expensive and relatively frequent procedures conducted in a hospital.

Mr. Neuhauser stated that in fact, hospital costs were being driven by outpatient costs, not by in-patient hospital stays which are where back surgery and spinal surgery are done. Since 2003, based on the Commission's studies of outpatient costs and work with the Legislature, research has led to identification of the Medicare fee schedules as the basis for paying outpatient costs and having a significant effect of cutting costs more than half. At the same time, inpatient surgery costs have not changed that much, although the number of surgeries and back surgeries has been declining. Inpatient workers' compensation surgeries are down 10 percent since the peak in 2001, and back surgeries have declined about 20 percent. Mr. Neuhauser stated that before the introduction of the SSSOP, there had been substantial decline in the frequency of back surgeries. On the other hand, there has been a trend toward more invasive spinal surgeries being performed.

Mr. Neuhauser stated that when compared to the rest of the country, California performs fewer non-occupational surgeries but one-and-a-half times more back surgeries per back injury. He stated that in workers' compensation, 3,000 back surgeries would be expected in California; however, there were about 8,000 back surgeries. Therefore, concerns about back surgery in California are justified because while back surgery was not driving an increase in hospital costs, it is more costly and much more frequent in the California workers' compensation system than in other jurisdictions, and California is moving toward more aggressive interventions for backs. Mr. Neuhauser then stated that there was also some concern that back surgery has poor outcomes for the worker. A study done in Washington State suggested that two years post-surgery, two-thirds of injured workers were not back at work.

Mr. Neuhauser stated that the SSSOP has been available to employers who object to the recommendation of spinal surgery by a treating physician. It was also available to workers whose treating physician objected to a negative decision at utilization review (UR). UR and the statutory and regulatory processes were adopted at the same time that the SSSOP was developed. They overlap to a great extent, and this has caused some problems with how the process should go forward for employers. Mr. Neuhauser stated that it will be clear that the process allowing the employer to use the SSSOP is unnecessary and that California needs to reserve the process for the workers. Mr. Neuhauser stated that the SSSOP includes very few doctors throughout California. He stated that on average, there is a very long distance between injured workers and doctors. There was concern that workers would not get the second opinion because of the burden of travel and consequently, would not get back surgery. Previous studies by the Commission suggested that one-third of injured workers who were required to go through the SSSOP did not complete the process and did not get surgery.

Mr. Neuhauser stated that spinal surgery appears to be much more heavily utilized in the California workers' compensation system than in workers' compensation systems nation-wide, in non-occupational medicine nation-wide, and even in California's non-occupational medical system. In particular, invasive spinal surgeries are increasing rapidly. Workers and employers

need access to good medicine while being appraised of all risks and the appropriateness of treatment

Mr. Neuhauser stated that issues about the low rate of second opinions may be unrealistic time frames and distance and access problems for workers. He further stated that the DWC should consider ways to deal with requests that miss the ten-day employer deadline, extended time frames, and penalties but not exclusion of requests. He also stated that the statute and regulations perhaps need to be clarified for SSSOP process within Medical Provider Networks.

Mr. Neuhauser stated that a survey of injured workers was conducted to determine: whether the threshold burden of getting a second opinion is deterring workers from obtaining necessary surgery, due to travel; whether the SSSOP is leading to poorer or better outcomes for workers in terms of RTW and health status; and whether the process should be modified to be more effective and/or more efficient.

Mr. Neuhauser stated that Commission staff drew a sample of all SSSOP requests submitted in 2005. There were 1,115 cases, of which 1069 had complete address information. A mail survey was conducted with follow-up telephone interviews, with a target of 300 interviews. The response was 386 surveys, and currently, there are over 400 responses, which is a fairly good response rate for a mail survey with limited phone follow-up.

Mr. Neuhauser stated that he was going to discuss treatment and control groups. The treatment group is those workers who went through the SSSOP, who were required to go through it as a result of an employer submitting a request for a second opinion and who were assigned a second-opinion doctor and received a second opinion from that doctor. The control group is another group of workers and employers who filed a request for a second opinion, but those workers were not required to go through the SSSOP because of the complicated regulatory requirements and the narrow time frames. Mr. Neuhauser stated that about one-half of the time, employers do not file all the necessary materials in the necessary time frames in order to require an injured worker to have a second opinion. Under those circumstances, they default to the situation in effect prior to when the SSSOP went into effect. The employer can deny the surgery through UR, and the injured worker can get the surgery through a second opinion outside of the process. Mr. Neuhauser stated that a similar percentage of workers who received a second opinion, whether or not they used the formal SSSOP, was about 85 to 88 percent.

Mr. Neuhauser stated that one of the concerns about a second-opinion process that does not go through a regulatory process is that injured workers might get sent to doctors with biases about spinal surgery. He stated that workers typically have little information about the tendencies of second-opinion doctors, but insurers or self-insured employers might have a lot of information about which doctor would favor their side. Mr. Neuhauser stated that there was concern that injured workers would not go to neutral doctors, as opposed to doctors randomly assigned by the DWC. He stated that for 65 to 71 percent of cases, the second opinion was in agreement with a recommendation of the need for surgery, a statistically insignificant range. Therefore, even in non-random situations, the results are about the same, or that about two-thirds of workers had the surgery, whether or not they used the second-opinion process.

Mr. Neuhauser stated that one difference between the treatment and control group is the percent of injured workers that actually were working at the time of the interviews. He stated that these workers were interviewed around June 2006, on average 12 months after they or their employer requested a second opinion. Twenty-four percent of those who went through the SSSOP were back at work, whereas for those who did not go through the SSSOP, 34 percent were back at work. Mr. Neuhauser stated that the percent of people back at work is low and that this may be because it takes a fairly long time to recover from spinal surgery; also, because the SSSOP has regulatory obligations, it may be somewhat slower than cases where surgeries are recommended by the employer. Mr. Neuhauser then stated that the percentage of workers who return to work within about a year after their spinal surgery request is between a quarter and a third. In fact, those who did not have surgery where the SSSOP recommended against surgery or they did not have surgery by choice, were 50 percent more likely to be back at work. Surgery therefore results in a poorer outcome, at least for the short-term to the medium-term. Mr. Neuhauser stated that it may be because those injuries were more severe, but that there was no indication of that. He stated that analyzing the age of the claim or the number of months following surgery indicated that 55 percent of those without surgery were back at work after 18 months following a request for surgery, and those with surgeries reached a plateau at 33 percent for workers who returned to work up to 18 months out. If they had surgery, their outcomes were poor and the poor outcomes continued for a period of time. Mr. Neuhauser stated that the data are consistent with the Washington State study which said that two-thirds of those who had back surgery, were still not back to work two years post-back surgery.

Mr. Neuhauser stated that there is one place where surgery does suggest a positive outcome. When survey participants were asked if their condition is better now than before the recommendation for surgery, those who did not have surgery stated that their backs were worse or much worse than before the recommendation. Those who had surgery generally stated that their back was the same, better or much better than before the recommendation. Mr. Neuhauser stated that these responses indicated that self-reported health outcomes are better with surgery, but that workers are also much less likely to be back at work.

Mr. Neuhauser stated that recommendations for the Commission include that the UR process introduced in 2003 could reasonably replace the SSSOP, making the second-opinion process unnecessary for the employers. However, once the employer has objected to the spinal surgery, workers still need an avenue to get a second opinion, and that the avenue needs to be one which injured workers think that the opinion will be fair. This is where the SSSOP seems to offer an appropriate solution because injured workers can get a high-quality, neutral opinion that can be used to challenge UR decisions and that in disputes sent to the Board, those decisions would be respected.

Mr. Neuhauser stated that despite the fact that workers had substantial distances to travel, none of these workers suggested that they did not get a second opinion because of any of the burdens of distance placed on them to get a second opinion. Unlike virtually every other study that has been reviewed about surgery, this SSSOP did not ration care to workers, based simply on not going through the process. That may be because the other surgeries were elective or less severe

and because spinal surgery may be the one area where injured workers are interested in getting a second opinion.

Mr. Neuhauser then offered some possible follow-up actions for the Commission. He stated that the data cover 6-18 months (an average of 12 months) after the request for surgery. There was very poor return to work (RTW) for those who had surgery, but better self-reported health outcomes. It could be useful to follow up with those injured workers in another year to see if their health outcomes remain substantially better and whether that resulted eventually in better RTW. Mr. Neuhauser stated that there is a lot of concern about back surgery and the level of invasiveness. He stated that he thinks that the report that comes out from the Commission should share information with workers about the potential outcomes from back surgery. He stated that he does not think workers necessarily realize that if they have back surgery, the likelihood of returning to work is still quite poor and that without surgery, the probability of returning to work is somewhat better. He stated that this may cause workers to somewhat delay or decide not to have surgery.

Mr. Neuhauser stated that the report will be completed in the next few weeks with this data and additional data. He stated that there are some interesting differences by gender. For example, women are twice as likely to get negative second opinions, which is something that should be investigated further. Men get positive second opinions about 85 percent of the time, and women get positive opinions about 50 percent of the time.

Chair Wei stated that before discussion is opened to questions, she would like to inform the audience that the Commission will take public comment at the end of each Agenda item, as well take general public comment after all the issues are discussed. Comments will be limited to three minutes per speaker. Public comment on the spinal surgery process will be requested after the Commissioners present questions.

Questions

Commissioner Wei asked if interviewees were questioned about whether they returned to the same place of employment or same job classification, and Mr. Neuhauser replied that interviewees were not asked that question, although interviewees who were not back at work were asked whether it was due to their injury. About 15 percent of those who were not back at work stated they were not back at work for reasons other than the injury, and 85 percent said there were not back at work because of their back injury. They were not asked if they had returned to work at their original employer or same job classification. Commissioner Wei asked if it were possible to follow up with those who did have surgery. Mr. Neuhauser replied that some of those who did not have surgery could have subsequently had surgery. He stated that there is also concern that those who self-reported better outcomes as a result of surgery deteriorate over the years. The current level overall of those getting back to work is 24 percent.

Judge Lachlan Taylor stated that when the SSSOP was adopted, the Commission was instructed by SB 228 to evaluate it and make recommendations for further legislation.

Judge Taylor stated that at the same time that the SSSOP was adopted, UR was adopted. The UR process starts with the treating physician's recommendation, and if an employer does not immediately authorize surgery, the employer conducts UR. If UR does not approve the recommendation, the employee may take "no" for an answer, or the employee may request an agreed medical evaluator/qualified medical evaluator (AME/QME) examination to resolve the dispute.

Judge Taylor stated that the SSSOP process is more convoluted than the UR process. He referred to the case of Deanna Brasher v. Nationwide Studio Fund, OAK 0296709, a panel decision by the Workers' Compensation Appeals Board in September. He stated that the Brasher decision found numerous paths following a treating physician's recommendation for spinal surgery, and he concludes that the Labor Code is not clear, and a clearer procedure is needed for resolving disputes. He stated that one proposal is for handling disputes similar to the manner in other cases outside of spinal surgery. An employer may authorize or conduct UR; if UR does not approve, the employee may take "no" for an answer or the employee may object to that UR denial and may request a medical opinion. The difference is that the medical opinion is from a highly qualified pool of spinal surgery second-opinion doctors, rather than from the overall QME pool.

Judge Taylor stated that it would appear that the way to modify the Labor Code would be to adopt the above proposal or abolish the SSSOP altogether. There are reasons to believe that the proposed process is valuable; as the DWC has indicated, this is a highly specialized pool of doctors and worth keeping for those reasons. He stated that the Commissioners have before them a draft of legislative language which would revise the confusing tangle of procedures. Judge Taylor stated that the proposal not have employers making medical decisions to object to a recommendation for spinal surgery without going through UR.

Commissioner Steinberg asked if the suggestion is that the SSSOP be removed entirely. Judge Taylor replied that the Commission recommends removing the SSSOP as a way for the employer to circumvent UR. The suggestion is that the SSSOP be kept as the way for an employee to contest a denial by UR of the physician's recommendation. Commissioner Steinberg then asked what the employer is losing, if anything, by being denied the right to the SSSOP. He further asked whether the employer achieves the same results through UR as through the SSSOP. Judge Taylor stated that the worst case for employers would be a situation in which the employee does not really need the surgery, but the records have been made to look like they do. When those records are sent to UR, it is going to look like this person needs surgery. UR would approve that case, and the employer would have no recourse. Judge Taylor stated that if employers have an objection that would be the one. Judge Taylor also stated that he would suggest that this complex procedure not be preserved just to protect against those few cases of doctors who falsify their records to justify surgery, as there are other ways to remedy this infrequent problem. Commissioner Steinberg stated that it is his understanding that under the present system, the employer really has two opportunities. Judge Taylor replied that the employer now has the chance to object to spinal surgery with no medical basis and invoke the SSSOP, which is one path. The employer also has the chance to conduct UR, getting a medical

opinion to decide whether or not there is a need, and then use the SSSOP at the employer's or employee's option after UR.

Chair Wei stated that Judge Taylor's recommendation seem to put a lot of faith in the UR process. She stated that there is concern both about under-utilization as well as over-utilization, especially as spinal surgeries become more invasive. She stated that she and others have heard anecdotes about doctors performing UR outside of their specialty, and she asked if there are some safeguards for having a highly qualified pool of second-opinion providers, providing that opinion first before going to UR. Judge Taylor stated that it does provide another way for employers to prevent unnecessary surgeries that might somehow slip through UR. He stated that it has been the anecdotal experience that UR is more likely to say "no" to needed treatment than to say "yes" to unnecessary treatment. He also stated that Commissioner Wei is correct, that it the recommendation does place a lot of faith in UR, as does the entire workers' compensation system and group health coverage. Requiring a second examination with or without just cause challenges the idea that UR is an appropriate process for injured workers and employers.

Chair Wei asked about cases where doctors not specialized in spinal surgery approve the procedure, and Judge Taylor replied that if this is the case, UR would have failed. UR decisions are supposed to be made by people with the appropriate qualifications. He added that the Brasher decision allows only 10 days for an injured worker whose treatment has been disapproved by UR to ask for a second opinion, a deadline that workers are not told about. The statute needs some amending. The amendments drafted for the Commission's recommendation are a proposed answer to that need.

Public Comment

Tim Madden from Medtronic asked Mr. Neuhauser if the survey looked at the time from the request for second opinion and the actual procedure, and then from the actual procedure to the outcome. Mr. Neuhauser stated that it is typically difficult to get accurate answers from these types of survey questions. Survey respondents may not accurately report, especially when the time is measured in days, let alone months. He stated that injured workers could be identified using other databases to report on timeframes, but since this was a mail-in survey, the questions needed to be fairly simple to ensure a good response rate. He then stated that if Mr. Madden wanted to submit something in writing about the importance of those timeframes, follow-up to obtain more precise data on prior condition and the precise dates of surgery would be considered. Mr. Madden stated if that follow-up were done and if there were a big gap from the time of the second opinion and the time of surgery, it might alter the survey results.

Mr. Madden stated that he had a second question related to Chair Wei's comment. He asked whether Mr. Neuhauser broke out the figure that 64 percent of the time, the SSSOP agreed with the recommendation for surgery by the specialties of the physicians who made those recommendations. Mr. Neuhauser stated that the survey did not target that information, but that it might be available. He also stated that the injured worker would not be particularly reliable source for that information. Mr. Madden stated that that it would be interesting to know the specialty of the doctor providing the second opinion.

Commissioner Wilson stated that he would like to hear more discussion about how UR panels are formed. Mr. Neuhauser stated that he was not particularly qualified to answer that question. Judge Taylor stated that the UR physician is supposed to be reviewing the decisions within that physician's competence to practice. He stated that there should not be a mismatch of specialties reviewing for surgery. Commissioner Wilson stated that the Commissioners would probably like to know that as it has been mentioned a couple of times. Judge Taylor responded that the UR process should provide for a doctor within the area of competence.

CHSWC Vote

Commissioner Davenport moved to approve the release of the report on the Spinal Surgery Second-Opinion Process pending the addition of information from the survey and post it on the CHSWC website, as well as to approve the release of the CHSWC Recommendation for the Spinal Surgery Second-Opinion Process Pursuant to Stats. 2003 ch.639 (SB 228) §48, and Commissioner Wilson seconded. The motion passed unanimously.

International Standards Organization (ISO) Study Preliminary Results

David Levine, Professor, UC Berkeley
Michael Toffel, Professor, Harvard Business School

Professor Levine stated that the International Standards Organization (ISO) study is a very different study from what the Commission usually does. He stated that the ISO program is not supposed to be about safety and health, but about the quality of products and services delivered, although it has been associated with concerns and hopes about safety and health. He stated that this study will look at the ISO quality program, but also pilot a method to look at just about anything that affects California workplaces. The data already collected can be used to examine factors that can affect hundreds of workplaces.

Professor Levine stated that quality programs are related to some of the elements of good jobs, such as skills, productivity, and sometimes wages. ISO is an international standard issued by the International Organization of Standards (Geneva). Companies pay an auditor to certify compliance with the standard. The standard is not about quality but about following procedures. The standard came from the military where the focus was on writing down procedures and following the procedures. More recently, written procedures have been added about improving quality standards and the focus has been on documented procedures. The ISO standard has spread around the world. Although the U.S. is a little behind Europe, in California, there are many ISO-certified companies, mostly manufacturers but also hospitals and others.

Professor Levine stated that the ISO standard could be certifying standards that are good for health. He stated that it is important to identify procedures in the workplace and to institutionalize routine audits to identify procedures and problems. Professor Levine then stated that in the ISO process, there are procedures for employee participation and feedback. The process could include elements of safety and health, especially as employees have more

autonomy at work and make suggestions about safety and health. He stated that there are case studies that demonstrate the way the process works. For example, L.L. Bean moves a lot of packages, and they have problems with people getting hurt. The company applies a quality program to surface problems, but also looks at root causes, such as an incentive scheme, at a deep level to try to change the workplace using the principles of quality programs. In addition, the company provides training and monitoring to determine if procedures are being followed.

Professor Levine stated that improved compliance with safety procedures usually results from the ISO process. He further stated that there is a related certification on environmental management topics, ISO 14,000, and that companies with ISO 9000 are likely to have ISO 14,000. ISO 14,000 identifies main hazards on the environmental front and suggests ways to alleviate them. An example of this is that if there are chemicals leaking, adjustments (such as tightening values) are made that are good for both the environment and for workers.

Professor Levine stated that ISO emphasizes that a company follows procedures rather than looks for alternative procedures. This has led to a concern that the ISO standard, or more generally Japanese management techniques or "total quality management," is associated with more repetitive motion injuries. Professor Levine stated that some prior studies found that factories with quality certifications have slightly higher cumulative injury rates because the ISO standard's emphasis on consistency. He stated that he was not convinced of those studies when he began this study with co-author Professor Michael Toffel with the support of the Commission. He stated that it is possible to imagine that a workplace could obtain ISO certification while already having repetitive motion problems. A case study he did in 1993 at the NUMMI plant shows the dual-edge nature of the ISO standard. The NUMMI plant is run by Toyota. It is the last auto plant in this half of the country, and they had the best quality program in the U.S. at the time. When there was a model change-over, there was a spike in repetitive motion injuries and the company did not do a good job fixing that problem. At a tactical level, the company was emphasizing continual improvement but that was focused on quality and productivity. Professor Levine stated that there was not a lot of encouragement to focus on safety, so at the strategy level, they were not putting a quality-improvement lens on the issue of ergonomic problems. It took a while to the company to see that it could do better.

Professor Levine stated that the Commission study is going to determine whether dangerous workplaces are adopting ISO 9000. The study will then see whether ISO 9000 reduces workers' compensation costs and injury rates or if it increases injuries, particularly cumulative motion injuries. Professor Levine stated that besides the Commission's funding support, CHSWC staff assistance in accessing data has been critical. Data were obtained from WCIRB and then matched with commercial data from Dun and Bradstreet on single-plant firms that had adopted the ISO 9000 quality program. The sample includes California plants in manufacturing that have three or more years of workers' compensation data and includes ISO adopters and comparison plants in the same industries. Professor Levine stated that over a span of a decade, ISO adoption is slow per year but is about 14 percent per decade. The plants in the study are not enormous as they are single-plant employers. This is the only way that the workers' compensation data can be matched with ISO data. The study is looking at the average loss

value and the number of claims. The study indicates that there are not that many serious cumulative injury claims per year.

Commissioner Wei asked if NUMMI was a single-plant employer and would be included in the study. Professor Levine replied that he does not know the identity of any of the employers in the study sample. NUUMI is a single-plant employer and on that basis, it could be part of the sample, but it would be unlikely to be included when the single-plant companies are matched with other single-plant companies of the same size, as there are no plants in California the size of NUUMI.

Professor Levine stated that the first step in the research is to determine who adopts ISO certification and whether the adopters are dangerous plants or safe plants. Although the results of the study are preliminary and any results should not be quoted, Professor Levine stated that the preliminary results show that unlike what was expected, ISO plants are slightly safer than other plants. In the next phase of the study, plants of similar size in the same industry will be matched based on similar workers' compensation experience or previous injury rates. If there is no similar comparison plant, then the plant is removed from the study.

Professor Levine stated that controls for any mitigating factors are taken into consideration in the study. The study looked at different survival rates of businesses as indicated by the WCIRB dataset. Some plants went out of business, some got bought, and some changed ownership or were renamed. The survival rates are strong for the ISO adopters. Professor Levine stated that the WCIRB does a good job of measuring which businesses survive. At two years, ISO adopters survive at a substantially higher rate than the comparison plants. Among the survivors, the study can look at employment and find that the adopters' payroll grew quite a bit larger than the payroll of industry peers. Again, this is an important result. The measure of growth is a total payroll exposure measure, in WCIRB terms, and the study will try to break that into its earnings component vs. the employment head count component in the follow-up phase.

Professor Levine stated that injury costs or injury rates show that comparison firms and adopters have the same trends and show the same increase in workers' compensation costs over time. Therefore, there is no evidence that cumulative injuries are a problem at ISO firms. Professor Levine stated that ISO should lead to an increase in the quality of the reporting. Most of that should have shown up as an increase in minor injuries, since something like a broken leg probably does get reported; however, the study showed that there is no big spike in the ISO adopter firms for minor injuries compared to the comparison firms. Similarly, the same results were obtained in the qualitative interviews, indicating that because ISO does not focus on safety, so there was not much interaction.

Professor Levine stated that ISO helps to creates good jobs and therefore, there is more payroll and more survival of businesses, which is positive for California workers. Considering this trend, concerns or fears about safety and health should be lower, and hopes about safety and health should be viewed as an unmet opportunity. He stated that this is just one study, and there is concern that because ISO firms are growing quickly, new hires may be an important factor, as new hires often are dangerous hires. Professor Levine stated that another study could be done

with individual-level data to break out the new-hire effect from the ongoing employees. Professor Levine also stated that there should be concern about good managers that both adopt ISO and lower injuries, as it may be that ISO has a negative effect on health but good managers have a positive effect on health. He stated that it is quite clear that ISO is mostly adopted because customers tell a company to do so. That is different from saying that it is adopted because of proactive managers.

Professor Levine stated that there are two important points to emphasize: (1) that single-plant firms could be different from multi-plant firms, as multi-plant firms have already adopted health and safety standards because headquarters has told them to do so; and (2) that other states that do not have a safety and health program like California does might see more benefit from adopting ISO. California's safety and health standard is specified in the Injury and Illness Prevention Program, which also has a communications system to ensure employee compliance, as well as inspections, evaluations, procedures, and training documentation. These standards and procedures that are already required by California are also required by ISO, so, as one of the interviewees put it, ISO does not affect safety and health in California because Cal/OSHA standards are much more detailed than ISO standards.

Professor Levine then stated that although California is a big state and therefore this is a big study sample, this type of study should be repeated every ten years. Professor Levine stated that there are two policy implications: (1) ISO appears to be a missed opportunity because putting procedures in place to improve health and safety would be an important benefit for workers; and (2) policy makers could think in the medium-term and try to encourage firms to integrate safety issues more completely into their quality program, so that workers are fully empowered to make suggestions about safety, as well as about improved quality and productivity, and so that safety improvement efforts treated at least as seriously quality and productivity suggestions. He stated that over time, one would hope ISO standards would lead to health and safety standards that are modest now.

Professor Levine stated again that this was an unusual pilot study because it was not specifically about a health and safety program. However, the method of using the data that is already collected for administrative purposes can be used to look at almost any program. Any training program or any change in incentives in the workers' compensation system or other parts of the safety and health system, such as Cal/OSHA inspections, can follow the same procedures as the study did. Professor Levene stated that careful documentation of the procedures of the study with the WCIRB, which has been extremely helpful in providing the data, is part of the study process. He also stated that the computer code and the procedures used in the study can be used to look at what Cal/OSHA does, as well as what workers' compensation, disability, and other parts of the system do. He stated that there is a real opportunity over the next few years to run a number of these studies and that he strongly encourages California to take the results from this study pilot and apply that to what is done about safety.

Questions

Commissioner Wilson asked Commission Executive Officer Christine Baker about the funding for the study. Ms. Baker stated that the Commission funded this study, that this is just an update of the study, and that the report is not out yet. Professor Levine stated that he expects the report to be done soon after the new year.

Commissioner Wei asked if the study identifies which are workplaces are union and which are non-union workplaces. Professor Levine stated that none of the data sources has that information. If there were an address of a unionized workplace, then it could be matched, but he does not know who keeps that information. Commissioner Wei suggested the Bureau of Labor Statistics might have a list. Professor Levine stated that information about union workplaces is not collected by the federal Bureau of Labor Statistics (BLS) and is difficult to get. Commissioner Wei stated that she thought that there might be significant findings based on union status. Professor Levine stated that there have been several good studies on unions for factors such as wages, and the findings were that unionized workplaces had better wages than non-union workplaces. He stated that he would look into this information if a source could be identified.

Commissioner Wei stated that in addition to wage differentials, there might be health and safety differentials. She stated that they hear anecdotally that union workers may feel more comfortable about filing grievances, complaints or workers' compensation claims because they have some contractual protection against retaliation and fear of reprisal. As a result, a spike of health and safety investigations at a union shop might be evident, because workers feel more empowered to speak up. Professor Levine stated that there is a level effect where unionized workplaces are more knowledgeable about the workers' compensation system and more comfortable using it. He stated that the question is the effects of the quality program above and beyond the fixed workplace. He again stated that there have been studies on wages and productivity but there have not been any on safety, and that he would be ready to add that to the study if the data existed.

Update on the Division of Workers' Compensation Activities: Regulations and Reports
Destie Overpeck, Chief Counsel, Division of Workers' Compensation

Ms. Overpeck reviewed the regulations that are currently ongoing. She began the update with utilization review (UR) penalties for violations of the UR timeline and procedures. Following public hearing on June 29th, the DWC did two volunteer audits of UR companies to see how the penalty structure as designed by the DWC would work and reviewed comments from the public hearing. By the end of October, there will be another 15-day public comment period for the revised UR penalties package. Chair Wei asked if this were prior to filing with the Office of Administrative Law (OAL) filing, and Ms. Overpeck replied that it is already in formal rulemaking. Ms. Overpeck then stated that penalty regulations for unreasonable denial of compensation, Labor Code Section 5814.6, had a public hearing on June 29, 2006; one 15-day comment period ended on September 27, 2006, and comments are being reviewed. It is not certain if there will be another 15-day public comment period but if so, it will be within the next few weeks. The medical treatment guidelines had a public hearing on August 23, 2006, and

revised regulations should be available by the end of the month. Ms. Overpeck then stated that the updates to the qualified medical evaluator (QME) regulations were made based on changes from the merger of the IMC with the DWC, and formal rulemaking is expected to begin by the end of the October or in November.

Ms. Overpeck then stated that the Official Medical Fee Schedule (OMFS) is in different parts, and although it is already a current regulation, the DWC is obliged by Labor Code to update the OMFS annually. The Inpatient Fee Schedule is updated annually and the updates are posted in November; the Outpatient Fee Schedule is updated annually and the updates are posted on or before January; the Laboratory and Pathology Fee Schedule is updated annually and will not be updated until April; the Durable Medical Equipment Prosthetics, and the Orthotics and Supply Fee Schedule is updated quarterly and the next update will be available in October.

Ms. Overpeck stated that the RTW regulations have been adopted in two parts. The first part is the fund for employers who improved the worksite and those regulations were effective as of August 18, 2006. The other part, which applied the 15 percent increase or decrease depending on whether an RTW offer was made, will be effective October 21, 2006. Ms. Overpeck also stated that there will be a public hearing on the repackaged drug and pharmaceutical regulations on October 31, 2006.

Ms. Overpeck then stated that a number of regulations are not with OAL as yet. These include: audit regulations being updated; benefit notices, which would probably be ready to be filed in October; electronic billing regulations; a physician fee schedule; ADA regulations; an update of Workers' Compensation Appeals Board (WCAB) forms and rules; and an updating of the ethics for workers' compensation administrative law judges.

Ms. Overpeck then stated that she would talk about the studies that the DWC is doing. One of the studies is the medical access study, pursuant to Labor Code Section 5307.2. There are three surveys that have been distributed: one to injured workers; one to physicians; and one to insurers, self-insurers and third-party administrators (TPAs). These surveys were mailed out and response can be by phone or internet. The injured worker survey response takes approximately 11 minutes over the phone, and the physician survey response takes approximately 17 minutes. Results are expected from 900 to 1,000 injured workers, 1,000 physicians, and 20 of the insurers, self-insureds and TPA groups. The injured worker survey asks about access to care and satisfaction with the physicians. The physician survey asks about if the physician is willing to see workers' compensation patients, if the physician's position has changed in the past few years, and if the physician does not see workers' compensation cases, why not. The insurer survey asks about the experience getting physicians to join medical provider networks (MPNs,) if they have them, any problem areas in the state that they know of, and how much they pay physicians. Ms. Overpeck stated that the DWC has been collecting the data since June 2006 and will stop collecting the data on October 18, 2006. The DWC expects the study to be published by the end of December 2006 or early January 2007. The work is being done by contract with the UCLA Center for Health and Policy Research, with Gerry Kominski. Ms. Overpeck stated that the DWC is very pleased about how the survey is going and believes that the surveys will help the DWC with forming decisions regarding the OMFS.

Ms. Overpeck then stated that data for the permanent disability (PD) study have been collected and will continue to be collected on an ongoing basis. So far, 22,000 PD ratings that were rated under the 2005 PDRS have been collected. The data provide a large enough sample to evaluate the schedule in three different types of studies. The Workers' Compensation Information System (WCIS) data and the Disability Evaluation Unit (DEU) data on injuries and RTW are being linked with Employment Development Department (EDD) data. Ms. Overpeck stated that the three studies designed to look at this data are a wage loss study, an RTW study, and an injury and illness incidence rate study. The software has been written and testing has begun with EDD.

Ms. Overpeck stated that the wage loss study involves calculation by the DWC of wage loss under the 1997 schedule and, as data are available, under the 2005 schedule. The study replicates four major studies in this area: the Douglas Crews and Allen Kruger study; the Les Boden and Monica Galisi study; the Biddle study; and the Reville study. The study will estimate wage loss just prior to Senate Bill (SB) 899 and compare it to wage loss in the 1990s.

Ms. Overpeck next stated that the RTW study will look at the 12-month period following the injured worker's date of injury. This data will be analyzed for all workers rated under the new rating schedule and that group will be compared to the baseline of workers injured and rated from the fourth quarter of 2000 through the first quarter of 2003, a three-year period. The results will be broken down by body part and severity. The DWC expects to find that if RTW has improved, it is expected that wage loss has been less.

Ms. Overpeck then stated that the third study, the injury and illness incidence rate study, will calculate incidence rates. The numerator figures come from the WCIS and the denominator figures from EDD, that is, injured workers over all injured workers employed by the same employers. These will be evaluated by industry, job tenure, firm size, injury type, body part, and PD severity.

Ms. Overpeck stated that the studies are expected to be completed by the end of the year. The wage loss study and RTW data will probably be by body part. Ms. Overpeck stated that all the available data have been collected and that the studies will be as comprehensive as possible and will be released as soon as possible. If there are technical questions, they can be sent formally in writing to the DWC, or Bill Kahley of the DWC will be happy to answer them informally over the phone or to discuss the procedures with interested researchers.

Questions

Commissioner Salazar asked if these studies were in-house studies. Ms. Overpeck stated that they were in-house studies; the DWC is working with the EDD but DWC researchers are designing the programs for all three studies.

Commissioner Wilson asked if the wage loss study would include the age of the worker. Ms. Overpeck stated that she did not know. Mr. Neuhauser stated that he knows that Rick Kilthau at the EDD has talked about linking driver's license data to the EDD file in order to establish gender and age. If he has done that, then for the first time, age can be taken into consideration. Mr. Kahley, research manager for the DWC, stated that the wage loss study would go beyond previous wage loss studies in that age, gender, occupation, industry would be included.

Commissioner Davenport stated that researchers should be cautioned that a lot of workers in California do not have driver's licenses. Mr. Kahley stated that the research will be from the WCIS database, and that co-variants for age, gender and occupation will be at a second stage of the analysis.

Commissioner Wei asked about the wage loss study estimating wage loss prior to SB 899. Ms. Overpeck stated that since there is currently no future wage-loss data, the DWC is using pre-SB 899 data. Time must pass before that wage loss occurs and that data become available.

Commissioner Wei asked if the study will be looking at wage loss pre-reform as opposed to wage loss post-reform. Ms. Overpeck stated yes, initially. Commissioner Wei asked if there were plans to monitor post-reforms. Ms. Overpeck stated that in the future the DWC will have that capability and will plan on doing it regularly. The studies could be run instantly, on a quarterly basis or whatever is necessary.

Commissioner Wilson asked whether the study would segregate public sector employers from private sector ones. Mr. Kahley stated that the initial studies so far have not looked at them separately, but that could be done. Commissioner Wilson stated that he thought it was important for this matter to be included in the study.

Commissioner Wei stated that it was her understanding of the RTW study that they would be comparing all workers over a three-year period running from 2001 through 2004. She asked if these were RTW rates pre-new PD schedule, not post-new PD schedule. Bill Kahley stated that in all of the analyses, the DWC is trying to compare pre- and post-parameters, that is, numbers that prevailed before the change and after the change. The wage loss studies, for example, will be performed using alternative methodologies that other researchers have improved, as well as what the DWC believes to be the state of the art methodology to estimate wage loss, incorporating the most recent knowledge and econometrics, etc. On that basis, the DWC will estimate wage losses as those wage losses exist now for injured workers rated under the old schedule. This would be in effect an update on the current knowledge base, which is the RAND study done ten years ago.

Commissioner Wei asked if the DWC study takes the RAND model and predicts what future wage loss is. Mr. Kahley replied that it did not and stated that the DWC study is estimating wage loss contemporaneously now for injured workers rated under the old schedule. The DWC will estimate wage loss using different models including the original RAND model; he further

stated that the DWC will be looking to see what the wage loss is in the different economic environment that exists today compared to ten years ago. Mr. Kahley then stated that with the understanding of the current economic environment, the DWC will conduct an empirical analysis of the results using the various models to estimate wage loss and contemporaneous wage loss of those injured workers rated under the old schedule. Then the DWC will apply the best model to estimate wage loss for those injured workers rated under the 2005 rating schedule, when those data become available.

Commissioner Wei asked if the study at the end of the year will be a predictive model or an estimation of wage loss under the new schedule. Mr. Kahley again replied that it would not be a predictive model, that by the end of the year, the DWC expects to have results from estimating three general kinds of models: (1) wage loss estimated for injured workers with PD rated under the old schedule, which is not predictive but actual; (2) estimated RTW rates for injured workers under the new schedule after 12 months and have as a benchmark RTW rates from injured workers prior to 2005; and (3) detailed estimates of illness and injury incidence rates sliced in different ways by different characteristics.

Commissioner Wilson stated that one of the concerns in the public sector in prior studies is the number of public workers that take early retirement and therefore sustain very little wage loss, but under previous studies, that was reported as significant wage loss. He asked if there were any way to correct for that in the public Employees Retirement System (PERS) or other records that might be available. Mr. Kahley stated that that was a good suggestion, and he stated that the DWC has a lengthy to-do list, and that given the miracles of modern computers and, most importantly, access to EDD data, the DWC can do all of these things.

Commissioner Wei asked for final clarification on RTW rates. She asked if those would be measured, rather than predictive, and she asked if the wage loss data would be prior to the new schedule. She stated that they would not know how the RTW rates translate into wage loss rates under the new schedule. Mr. Kahley stated that that is correct and only by inference can the wage loss rates be derived directly. To actually get the wage loss for injured workers rated under the new schedule, historical experience would be require, but that historical experience has not happened yet.

Commissioner Wei asked what the third study will focus on. Mr. Kahley replied that it would be injury and illness incidence rates. He stated that currently, the BLS nationally and the Division of Labor Statistics and Research (DLSR) in California conduct a survey of around 65,000 employers, and on the basis of a sample survey of employers, calculates aggregate illness and injury incidence rates. There is a lag in time for these data to be available to the public. By contrast, the DWC is in the process of using EDD data along with WCIS information to calculate illness and injury incidence rates by detailed industry categories, at the four-digit NAICS level, which is the codification system for classifying industries. The DWC will also be able to provide detail on incidence rates, as Ms. Overpeck described, for parts of the body, and other characteristics of the claimant.

Commissioner Wei asked if the study will provide a picture by industry. Mr. Kahley replied that this would be available on a quarterly basis and that he believed that the stakeholders in

California would find this information highly useful. He further stated that this data would probably trigger further research. Commissioner Wilson stated that it was encouraging that everyone would now be able to use WCIS information.

Commissioner Wei asked if the methodology of the three studies could be drafted and submitted to the Commission. Mr. Kahley replied that the DWC would do that.

Commissioner Wei stated that Governor Arnold Schwarzenegger signed a bill about workers' right to pre-designate a physician and that may have some implications to the regulations that the DWC already has on file. She asked if the DWC had plans to update the regulations. Ms. Overpeck stated that she had not looked at that but would do so. Commissioner Wei stated that there were important implications from these changes and she would be interested in the DWC's analysis.

Commissioner Wei asked Ms. Overpeck about the physician fee schedule regulations and if the Resource-Based Relative Value System (RBRVS) was part of that mix. Ms. Overpeck stated that the Lewin Group is doing a study for the DWC, and once that study is received, the DWC will decide what to do about the regulations. Ms. Overpeck stated that she did not know when that study would be completed but that she would try to find out.

Commissioner Steinberg asked for clarification on the PD study on whether there would be a report by the end of the year on the wage loss PD study. Ms. Overpeck replied that there would be a report. Commissioner Steinberg asked which years of wage loss have been used in the modeling. Mr. Kahley stated that the wage loss years would be for injured workers rated under the 1997 schedule. The three-year proportionate wage loss period will be from the fourth quarter of 2000 into 2003 and through the second quarter of 2006, the most recent quarter that the DWC will have data from the EDD. Commissioner Steinberg asked if the report will be available at the end of the year. Mr. Kahley replied that the report will be available subject to receiving data from the EDD. He stated that the programming has been done and that the DWC has done all that it can to collect data and information to evaluate the impacts of the PD schedule.

Commissioner Wei asked Ms. Overpeck whether the DWC has a plan, once these studies are completed, for what the next steps will be. Ms. Overpeck stated no there was no plan at this time and that the DWC needs to see the results of the study in order to interpret them and figure out what to do.

Update on CHSWC Study on the Medical Reforms
Barbara O. Wynn, RAND

Ms. Wynn stated that she would discuss the study on medical reforms to evaluate the impact of the reform provisions on medical care and then would ask the Commission to identify specific

issues that need priority attention. Ms. Wynn stated that the recommendations last year included a very strong need for an ongoing monitoring system. She also stated that the WCIS would help in collecting data but that good metrics would also be needed to evaluate system performance. She stated that the new study began July 1st to evaluate the impacts of the reform provisions on medical care including: medical necessity provisions, including the treatment guidelines, utilization review process, and caps on chiropractic and therapy services, with questions about the costs and patterns of care and work-related outcomes; medical provider networks, especially access-to-care issues and the kinds of differences in costs and patterns of care between the broad medical networks and more selective networks that have been established as well as non-network care; impacts of the fee schedules, particularly the OMFS which has expanded to include outpatient surgery facilities and the shifts in the site of care for ambulatory surgery.

Ms. Wynn stated that a second component of the study would consider how pay-for-performance incentives might be used in workers' compensation medical care. Both Medicare and group health plans are using structured financial incentives to improve the quality of care. Ms. Wynn stated that new and evolving pay-for-performance programs provide incentives to improve quality of care. One example is Integrated Healthcare Association's statewide initiative in California which involves seven health plans and 225 physician groups representing 35,000 California physicians. This initiative makes bonus payments for attaining evidence-based performance goals in three areas: clinical measures; patient satisfaction experiences; and investment in information technology. Ms. Wynn stated that this initiative also includes public reporting of physician group performance to the Office of Patient Advocates and that the results are published on the Office's public website. Preliminary analysis of the first two years of this program shows consistent improvement in all the clinical outcomes and in patient satisfaction, as well as substantial improvement in the use of information technology.

Ms. Wynn stated that pay-for-performance programs involve several procedural steps which include: deciding the focus and developing measures that are tied to the goals and objectives; developing the process to collect the data and do the measurement; and deciding on how the program would be financed and what it would actually reward, whether by improvement, assessing the higher performers relative to the lower performers, or by meeting established goals.

Ms. Wynn stated that the research will be conducted over two years. Key informant interviews done to update earlier findings are in progress. Empirical analysis of administrative data for impacts of provisions will include ongoing discussions with the California Workers' Compensation Institute (CWCI) on getting access to data and case studies of four medical networks. A roundtable of stakeholder representatives to discuss pay-for-performance strategies and issues is planned for early December 2006.

Ms Wynn stated that the research is expected to produce a White Paper on pay-for-performance in March 2007, an interim report with summary of interviews and early findings in May 2007, and a final report one year later in May 2008. Interviews to date with key informants are already raising common themes including: concerns about the American College of Occupational and Environmental Medicine (ACOEM) guidelines, including: that chronic conditions and topical areas not covered by the guidelines and that the reopening of closed cases and the application of

the guidelines to these cases is problematic; concerns about the utilization review (UR) process, stressing the need for enforcement regulations and the use of out-of-state reviewers which is also controversial, as well as the process being administratively burdensome especially for physicians trying to adhere to the guidelines; and concerns about access within medical networks, including the issue of physicians not willing to treat injured workers, which seems to be improving; and fee discounting, which is still an issue for physician groups.

Ms. Wynn stated that early impressions from the interviews and studies conducted by other researchers include that there are substantial reductions in utilization and medical costs, but the impact on clinical quality and on work-related outcomes and expenditures, especially temporary disability, is not known. Ms. Wynn also stated that analyzing the impact of specific provisions will be challenging for several reasons, including that medical provisions are inter-related and interact with changes in temporary disability, that no unified database is available, and that there are topics, such as pre-designation and the $10,000 payment before a compensability determination, that may not be able to be addressed. Other concerns focus on incentives for various stakeholders, an issue that warrants analysis, as well as that more DWC regulatory oversight is needed, particularly with regard to the UR process and medical networks.

Questions

Commissioner Steinberg asked about the reopening of closed cases because they are inconsistent with the ACOEM Guidelines and whether there are any suggestions to handle this problem. Ms Wynn replied that a court case on this is moving through the court process and that they will follow that case; however, it is premature to make any recommendations on it at this time.

Commissioner Davenport asked if the study would be able to differentiate between actual medical reforms and the legal system that overlays the entire workers' compensation system, as well as distinguish between what is medical care and what is a legal complication. Ms. Wynn stated that they will look at specific conditions and compare before and after for those conditions on a number of different measures.

Update Regarding Quality Studies and Medical Treatment Guideline Issues
Teryl Nuckols, MD, MSHS, David Geffen School of Medicine at UCLA

Dr. Nuckols stated that she would provide an overview of two areas: guideline evaluation issues including discussion of topical limitations of the ACOEM Guidelines and of updating issues and potential research; and carpal tunnel quality measures, including partnerships, progress in the research, and future anticipated milestones.

Dr. Nuckols stated that RAND's 2004 evaluation of guidelines identified ten common and costly clinical topics to examine in detail. Five finalist guidelines were examined focusing on three treatments which included surgery, physical therapy and chiropractic manipulation, which were provided for three common disorders, which were lumbar spine, shoulder, and carpal tunnel. By distinguishing lumbar spinal fusion and decompression surgeries, ten topics were identified. Dr.

Nuckols stated that a multidisciplinary panel of expert clinicians from around the country judged guideline comprehensiveness and validity for each topic. Due to limited time, the panel was unable to include all clinical topics relating to work-related injuries, or even all important clinical topics.

Dr. Nuckols stated that although the panelists preferred the ACOEM Guidelines to the other finalist guidelines, they felt it "barely met standards" and that there were problems with comprehensiveness or including physical therapy and chiropractic manipulation and physical therapy for all three disorders. There were also problems with validity for the ten topics for physical therapy and chiropractic manipulation in two out of three disorders and lumbar spinal fusion surgery. Dr. Nuckols stated that stakeholders also reported that the ACOEM Guidelines have some additional limitations including the areas of chronic pain, occupational therapy, acupuncture, devices and new technologies. There were also concerns that utilization managers have applied the ACOEM Guidelines to topics not even mentioned in the guidelines, for example, toxicology.

Dr. Nuckols stated that these limitations led to several key recommendations that still hold today and pertain to the topical gaps. For some of the important weaknesses in the ACOEM Guidelines, it was recommended that the Department of Industrial Relations (DIR) should replace the ACOEM Guidelines with better guidelines as quickly as possible; guidelines for lumbar spinal fusion, because it is risky, costly and increasingly common procedure, are a high priority; and that better guidelines should be available for physical therapy and chiropractic manipulation. She also stated that DIR should clarify the topics to which the ACOEM Guidelines apply so that utilization managers know which topics the ACOEM Guidelines address adequately. Dr. Nuckols stated that certain tests and therapies should be priority topics for future evaluations because they are common and contribute to major medical costs. These include magnetic resonance imaging of the spine, spinal injections, spinal surgery, physical therapy, chiropractic manipulation, surgery for nerve compression syndromes like carpal tunnel, shoulder surgery and knee surgery, and utilization management.

Dr, Nuckols stated that according to a letter that ACOEM sent to Carrie Nevans, Acting Administrative Director (AD) of the DWC, ACOEM plans two major types of updates. The first is ACOEM Practice Guideline Insights, a quarterly publication that clarifies ACOEM recommendations and provides an ongoing evidence-based review of new studies, as well as an in-depth, updated analysis of interventions discussed in ACOEM. Dr. Nuckols stated that these quarterly updates may alter ACOEM's official positions on what a clinical situation might be. She then stated that the second change that ACOEM is planning is a rolling set of guideline updates over a three-year period; this will be a progressive refinement and clarification of the current guidelines with the first updates to be issued in late 2006 or early 2007.

Dr. Nuckols next stated that there are some issues that the ACOEM updates raise including that older material could still be used after updates are available and this is undesirable because new research evidence makes many guidelines out of date after three years and the ACOEM Guidelines were last updated in 2004. She stated that using a version recognized as out-of-date by the developer might foster litigation, and using the updated sections without some sort of an

independent evaluation implies that ACOEM, a medical specialty society, would effectively be setting policy in California. Dr. Nuckols stated that some ongoing system of checks and balances is needed.

Dr. Nuckols then stated that the limitations and updating issues for the ACOEM Guidelines suggest several considerations for guideline research. ACOEM may start updating its guidelines this year; therefore, guideline research should probably begin soon. Dr. Nuckols identified several unanswered questions which include: should the quarterly publications be considered part of the ACOEM Guidelines or merely supplementary (i.e., optional) material?; how should the rolling updates be evaluated, especially since one set of revised guidelines would be easier to evaluate?; will all users of the ACOEM Guidelines be aware of the quarterly publications and rolling updates, and have equal access?; and should DIR implement the updates immediately on a presumptively correct basis (i.e., while pending evaluation) or wait until evaluations are complete? Dr. Nuckols also stated that a few common and costly tests and therapies comprise about 40 percent of medical costs; therefore, future research efforts should emphasize identifying high-quality guidelines for these priority topics. She then stated that there are several unanswered questions and concerns including: how common or costly a test or therapy should be for there to be a "presumptively correct" guideline; how some injuries that are rare should be treated; that guideline evaluation and updating are costly and UR is costly; that a guideline for distinguishing high-priority from low-priority topics would be needed; and whether advisory guidelines that are not used as "presumptively correct" should be used for low-priority topics.

Dr. Nuckols stated that prior evaluation found that one guideline set did not address many common and costly tests and therapies adequately; therefore, DIR should reconsider whether a single guideline set would be preferable to having one or more higher-quality guidelines for each topic. Unanswered questions include: if a comprehensive guideline set is used, what should be done when the set is weak on certain topics?; alternatively, if several guidelines are used, what should be done when there is overlap and there are conflicting recommendations?

Dr. Nuckols then stated that an approach that could be considered would cover important topics but minimizing research and regulatory costs would involve the following steps: decide that "presumptively correct" guidelines are only needed for recognized priority topics; identify one or more high-quality guidelines for each priority topic; repeat the evaluation process at three-year intervals; include the most up-to-date sections of the ACOEM Guidelines available at the time and ignore subsequent updates; endorse one or more high-quality guidelines for each priority topic; ensure that when guidelines make conflicting recommendations in a particular clinical situation, utilization managers could implement the least restrictive recommendation; identify advisory guidelines for lower-priority disorders; and use the National Guidelines Clearinghouse as a source for guidelines that meet basic quality standards, though these guidelines might not have the highest standard.

Dr. Nuckols stated that the objective of the research on carpal tunnel syndrome would be to develop objective, explicit measures that enable researchers, payors, and policy makers to evaluate the quality of the medical care provided to patients with carpal tunnel syndrome. Ideally, the measures would address diagnosis, non-surgical treatments and surgery. She then

stated that the steps to take to develop measures include: decide which specific topics should be covered; develop preliminary measures by experts in each specialty; conduct systematic literature searches for each preliminary measure; convene multidisciplinary expert panels to evaluate the validity of each preliminary measure; specify explicitly how the final measures should be applied to administrative data and medical records; and pilot test and evaluate the measures and refine the final measures.

Dr. Nuckols stated that efforts to build partnerships include a Commission contract supporting measure development started in June 2006, which is enough to cover development of a limited set of measures and a commitment by Zenith Insurance to contribute $250,000. She stated that at least $250,000 more is needed to specify and pilot test an entire set of measures. The effort to identify additional funding partners needs to continue and that an application has been made to the Arthritis Foundation for funding. She hen stated that if several funding partners each committed to small amounts of support, the goal could be achieved.

Dr. Nuckols stated that research progress includes working on defining clinical topics to cover training clinicians to write preliminary measures and recruiting expert panelists. She then stated that anticipated milestones are: January 2007, when most preliminary measures will be written; April 2007, when literature searches for each measure will be complete; May 2007, when the panel will evaluate measures addressing surgery; and June 2007, when the panel will evaluate measures addressing diagnosis and non-surgical treatment.

Questions

Chair Wei suggested that as many as possible of the participants from the 2004 recommendations per the Labor Code should be part of the nomination process for the study. Dr. Nuckols replied that the objective of the selection process is to get a national representation, with California participants constituting only 20 percent of the panel. She also stated that she would be happy to share the names of the panel participants.

Executive Officer Report
Christine Baker, CHSWC Executive Officer

Executive Officer Christine Baker reported on the activities of the Commission. She stated that over the past year, a number of studies have been approved, such as the RTW wage loss study with RAND, the fraud studies that are being conducted jointly with the Fraud Assessment Commission, the study of the evaluation of the medical reforms, and the quality study with UCLA/RAND. She stated that all of these studies take major efforts to secure data sources, and each requires memos of understanding and agreements with different agencies such as the EDD, the Department of Insurance (DOI) and the DWC. Commission staff has technical meetings with data staff and others to ensure the reliability of data requests. To date, there have been

significant delays obtaining data from the EDD but those delays may be resolved this week. Ms. Baker stated that confidentiality requirements, data sampling and other very lengthy and complicated tests are being done.

Ms. Baker stated that work on the apportionment study is being put on hold temporarily because of the recent decision by the WCAB to stop making determinations on the calculation of dollar awards in apportioned cases. There is a split among the courts of appeal on how to convert an apportioned disability rating into dollars. The Supreme Court or the Legislature will have to resolve the conflict. Until then, any decision made by the WCAB trial judges or Appeals Board is likely to be appealed and left unresolved. So the Appeals Board Chair has advised the trial judges to defer the issue in all cases until the conflict is resolved. Ms. Baker stated that meaningful apportionment decisions are not expected for a while, so efforts to obtain apportionment decisions from the DWC for study are likely to be suspended. She stated that the staff is working with Judge Larry Swezey on a review of the case law for publication in a national journal and that Mr. Neuhauser will continue to observe the apportionment of calculations in DEU ratings. It is only judicial determinations of apportionment that are being deferred.

Mrs. Baker then stated that Commission staff has been finalizing the 2006 Annual Report. The Annual Report serves as a benchmark, and the Commission receives many requests for this information. The draft was sent to Commissioners for review, and except for final editing and some recent updates to the savings from the reforms, the draft is ready for approval.

CHSWC Vote

Commissioner Salazar moved to approve the release of the CHSWC 2006 Annual Report pending revisions and updates, and Commissioner Schwenkmeyer seconded. The motion passed unanimously.

Ms. Baker stated that Commission staff has also been developing background work for a number of issue papers on issues such as RTW. Work with the janitors and maintenance workers is moving forward, and some of the next steps will include getting estimates of the savings. Staff is in the process of identifying employers who would like to participate in the study and in a round table with insurers. Ms. Baker also stated that staff has also attended regulatory hearings on treatment protocols and other issues when possible, and has responded to information requests from the California Department of Corrections and Rehabilitation as they consider the feasibility of a carve-out pilot, which they currently do not have the legislative authority to enter into. Ms. Baker stated that next week, two Commission staff will attend the national conference on the Utilization Review Accreditation Commission to develop more background knowledge so staff can contribute to the continuing improvement of California's system for delivering appropriate medical treatment to injured workers.

Ms. Baker stated that a number of reports that have been out for public comment; all comments, when appropriate, have been incorporated and these reports are ready to be finalized and posted. The reports are: Barriers to Occupational Health Services for Low-Wage Workers in California;

Report on the "Forum on Catastrophe Preparedness: Partnering to Protect Workplaces" held on April 7, 2006; and the Impact of Physician Dispensing of Repackaged Drugs on California Workers' Compensation, Employers' Cost and Workers' Access to Quality Care.

CHSWC Vote

Commissioner Wilson moved to approve the release of the reports and posting them on the website, and Commissioners Thackeray and Davenport seconded. The motion passed unanimously.

Ms. Baker stated that during the Labor Day holiday, the International Association of International Accident Boards and Commissions (IAIABC), of which she is a member, invited her to represent them in Shenzhen, China, and report on injury tracking in the United States with a particular emphasis on respiratory illness reporting. She stated that she did this on vacation time, but it was a wonderful experience and she is grateful for the opportunity to serve the Commissioners and be in a position to present such information.

Ms. Baker then stated that Commission staff is often called upon by the legislative staff to answer questions regarding studies and often receives requests to brief employer groups and labor groups on the Commission's work. She stated that next week she will serve as chair of a forum in Washington, D.C., for the National Academy of Social Insurance (NASI), where information on much of the Commission's research on wage loss, quality of care, integrated benefits and 24-hour care will be presented. Ms. Baker stated that the Commission's work is now well recognized around the country because the Commission has empirical studies to support its recommendations.

Ms. Baker next stated that at the request of the Chair, Commission staff is preparing for an RTW round table. An issue paper had been prepared for Assembly member Nava on some improvements needed which the Commissioners approved, and this paper will serve as a basis for the round table which is set for November 17, 2006. In addition, Commission staff has been asked to attend meetings on medical care delivery in California, which include the effectiveness of the current certification of the medical provider and the qualified medical evaluator (QME) process.

Ms. Baker stated that as part of the work on proof of coverage, Commission staff has found that a more thorough review of current uninsured employer benefits should be conducted. This area is being looked at in the fraud studies, but Commission staff would like the authority to put a proposal together to expand this issue to cover benefit delivery.

Ms. Baker stated that Commission staff is pleased to serve and is devoted to the work that is done for the public good. She stated that Oliva, one of the Commission staff assistants, has been on maternity leave and will return in November, and that Janice is expecting in April. Dr. Teryl Nuckols is also expecting.

Proposal for a Symposium on Carve-outs

Chair Wei stated that Commission staff has presented a proposal for a symposium on carve-outs, which will continue the Commission's work of informing eligible employers and employees about carve-outs.

CHSWC Vote

Commissioner Davenport moved to approve the proposal for a symposium on workers' compensation carve-outs, and Commissioner Wilson seconded. The motion passed unanimously.

Ms. Baker stated that a Workers' Compensation Medical Booklet and Fact sheet have been prepared. Minor editing and updates are being done to these materials but that they are ready for approval for release.

CHSWC Vote

Commissioner Davenport moved to approve the release of the Workers' Compensation Medical Booklet and Fact Sheet with minor edits and updates as needed, and Commissioner Thacker seconded. The motion passed unanimously.

Questions

Mr. Dillon asked if the Guidebook that the Commission put out earlier would be updated with current information. Ms. Baker replied that the Commission will use technical resources to incorporate information about the recent SB 899 reforms into that Guidebook.

Update on Permanent Disability Data from the DIR Disability Evaluation Unit
Frank Neuhauser, UC Berkeley

Mr. Neuhauser stated that there has not been any significant change since the last presentation on DEU data to the Commission. A new sample of about 11,000 cases from the DEU has been received so that data are available for cases through August 31, 2006. He stated that about 22,000 cases have now been rated under the new schedule and the results are consistent. For summary ratings, there is a reduction of a little more than 40 percent in the average rating and a little over 50 percent reduction in the reduction of benefits to injured workers. For represented cases, or those represented by an attorney, the percent of reduction of benefits to workers is in the mid-forties percent.

Mr. Neuhauser then stated that on the issue of apportionment, the figures also stayed about the same, with about 11 percent of cases getting rated on apportionment to causation, and that accounts for a reduction of about 5 to 6 percent of benefits to workers since the AMA *Guides* have been in place. He stated that these figures represent only minor changes and that there is now confidence that the estimates accurately reflect the impact of the new schedule.

Chair Wei asked if the mid-forties figure on the consult ratings was dollars or ratings. Mr. Neuhauser replied that it was in the low forties for the reduction in the PD average rating and about 46 to 48 percent reduction for the average benefits to workers. Chair Wei stated that she hopes the DWC can work with the EDD to provide the data soon so the study can be updated quickly.

Public Comment

Mr. Dillon stated that he very much appreciates the work of Commission staff and that they have made themselves available at all times to provide information on Commission recommendations and resources.

Adjournment

The meeting was adjourned at 12:40 p.m. The next Commission meeting is scheduled for Friday, December 8, 2006, in Oakland.

Approved:

_____ _____

Angie Wei, Chair Date

Respectfully submitted:

_____ _____

Christine Baker, Executive Officer Date